

Enhancing Resilience in Children: A Proactive Approach

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Many clinical practitioners today are interested in helping children be more resilient. The authors briefly review the literature and identify protective factors that are related to or foster resilience in children. After discussing individual and family intervention strategies currently in use, the authors present a practical, proactive, resilience-based model that clinicians may use in a group intervention setting. The model entails interactive identification of protective factors with children, free play and behavioral rehearsal, training in relaxation and self-control techniques, practice in generalizing skills acquired, and active parent involvement. Implications of this group intervention model are discussed.

Keywords: resilience, children, social skills, groups, cognitive-behavioral therapy

Vala is a 16-year-old Russian girl who first came to our practice at age 6. Neglected as a child, separated from her younger sister, and taken to an orphanage following her mother's suicide, she was adopted by an American family and came to this country. The tribulations she experienced were extreme. However, because of her intelligence, easygoing temperament, and other personal strengths, as well as loving support of family and friends and a positive school environment, she is functioning well today and appears to be successful and happy.

Many children encounter fewer and less severe traumatic experiences than did Vala. Yet they do experience the inevitable stresses and adversities in life that may challenge their healthy development and successful functioning. In the past three decades, a group of children have been identified in the research who appear to have fared well despite exposure to severe adversity. These children, who have been referred to as *stress-resistant*, *invulnerable*, and, more recently, *resilient*, were found to possess certain strengths and to have benefited from protective influences that helped them to overcome adverse conditions and to thrive. As practitioners, we must understand what environmental factors place children at risk and what protective factors may be fostered to enhance and strengthen resilience in children.

In this article we define resilience and provide an overview of the literature and recent advances that are guiding work in the field today. We then define and discuss protective factors linked with the resilience process. Finally, we offer clinical implications for individual, family, and group therapy with children.

Definitions of Resilience

The term *resilience* has been defined in many ways. Masten, Best, and Garmezy's (1990) definition of resilience as "the process of, capacity for, or outcome of successful adaptation despite challenging or threatening circumstances" (p. 426) is one of the more familiar and widely accepted in the field. Many definitions of resilience require specification of an identified risk or challenge to which an individual is subjected, followed by some defined measure of positive outcome. However, controversy remains regarding what constitutes resilient behavior and how to best measure successful adaptation to adversity. Some have suggested that a resilient person must show positive outcomes across several aspects of his life over periods of time (Cicchetti & Rogosch, 1997). Further, resilience is not a one-dimensional, dichotomous attribute that persons either have or do not have (Reivich & Shatté, 2003). Rather, resilience implies the possession of multiple skills, in varying degrees, that help individuals to cope.

For the purpose of this article, we define resilience broadly as those skills, attributes, and abilities that enable individuals to adapt to hardships, difficulties, and challenges. Although some attributes are biologically determined, we believe resilience skills can be strengthened as well as learned.

Early Studies in Resilience

Early clinical case descriptions spawned an interest in determining why some children manage to cope with adversity whereas others succumb. One such case of a 14-year-old Swiss girl was described by Bleuler (1984; as cited in Anthony, 1987a). "Vreni," in the absence of her mother (who was hospitalized with mental illness), raised her siblings, cared for her alcoholic and physically compromised father, and later reported having a happy marriage and contented life. Anthony's description of "invulnerable" children (Anthony, 1987b) and Murphy and Moriarty's "good copers"

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(Murphy & Moriarty, 1976) sparked early interest as well. Rutter's Isle of Wight studies (Rutter, Tizard, Yule, Graham, & Whitmore, 1976), large-scale longitudinal undertakings such as Project Competence (Garmezy, Masten, & Tellegen, 1984; Masten, 2000), and Werner's now four-decade-long study of high-risk infants born into poverty on the Hawaiian island of Kauai (Werner, 1993; Werner & Smith, 2001) have helped to lay the groundwork for what we know today.

Recent Advances

The emerging research in the area of resilience encompasses many areas. These include investigations of children from various cultures (Grotberg, 1995; Hart, Hofmann, Edelstein, & Keller, 1997), studies of the influences of biological mechanisms (Curtis & Cicchetti, 2003; Rutter, 2002), new findings in recovering to normal functioning in varying stages of development, research on the impact of internal challenges, and theories on the processes that promote resilience under nonrisk conditions. We consider the latter three areas below.

Evidence that children can recover and develop normally comes from a recent study of Romanian children who experienced severe deprivation in orphanages and were later adopted into nurturing homes in the United Kingdom. At the time of adoption, most of these children showed substantial gross physical and cognitive lags in development. Later, when assessed at age 4, many of these adoptees showed significant "catch-up," both physically and cognitively (Rutter & The English and Romanian Adoptees (ERA) Study Team, 1998; Rutter, Pickles, Murray, & Eaves, 2001). Follow-up in Werner and Smith's (2001) Kauai study revealed that even those individuals who were troubled as adolescents were able to change the course of their lives in dramatic ways by making wise choices and taking advantage of opportunities, for example, by continuing their education, learning new skills, joining the military, relocating to break ties with deviant peers, and choosing healthy life partners.

Major longitudinal studies have followed the outcome of individuals with learning disabilities and attention-deficit/hyperactivity disorder (ADHD) to determine those factors that contribute to their resilience (Gerber, Ginsburg, & Reiff, 1990, and Spekman, Goldberg, & Herman, 1992, as cited in Katz, 1997; Werner & Smith, 2001). Studies reveal that resilient learning-disabled youth search for personal control over their lives, possess a strong desire to succeed, set goals, demonstrate high levels of persistence, and are willing to seek out and accept support. Resilient learning-disabled young adults report better ability to identify their successes and unique strengths, are more likely to report turning points in their lives as motivations to overcome their challenges, and show a stronger self-determination (Miller, 2002). Hechtman (1991; as cited in Katz, 1997), in a long-term prospective follow-up of young adults diagnosed with ADHD as children, found that the presence of an influential person in their lives who believed in them (e.g., parent, teacher, coach) was most significant. Effort is being put forth to better understand the risk and resilience processes in this population of youth (Murray, 2003).

Masten (2001) challenged the notion that resilient children possess some rare and special qualities. She suggested that resilience stems from a healthy operation of basic human adaptational systems. If systems are intact, children should develop appropriately even if challenged. However, if children's basic adaptational

systems are impaired, prior to or following challenge, the risk for problems in development is increased.

Protective Factors

Protective factors are "influences that modify, ameliorate, or alter a person's response to some environmental hazard that predisposes to a maladaptive outcome" (Rutter, 1985, p. 600). Protective factors arise from within the child, from the family or extended family, and from the community (Werner, 1995). A child's intelligence, success at making friends, and ability to regulate his behavior are examples of internal strengths that promote resilience. Examples of external influences that enhance resilience are competent parents, friendships, support networks, and effective schools.

Protective factors that help children successfully adapt and cope with life's challenges must be viewed in the context of their individual cultures and developmental stages. The International Resilience Project (Grotberg, 1995) showed, for example, that faith operates as a stronger protective factor in some cultures than in others. In addition, children's developmental and cognitive levels affect their ability to use various protective factors, as do internal and biological vulnerabilities such as ADHD and learning disabilities.

While researchers forge ahead to examine the complex interplay between risk factors, protective factors, and prevention and intervention strategies, practitioners need to know what factors may be strengthened in children to further promote positive appropriate responses. Below we discuss six protective factors that appear to buffer against risk factors. These factors have been categorized in accordance with the accumulating resilience literature and our experience in clinical practice. These six categories are not mutually exclusive. Many of the components described in one factor are related to components in other factors. For example, a child who can self-regulate is more apt to make friends and connect with others. A child who experiences academic success is likely to have higher self-esteem. The presence of several factors seems to enhance performance in multiple arenas.

Proactive Orientation

Proactive orientation, that is, taking initiative in one's own life and believing in one's own effectiveness, has been identified as a primary characteristic defining resilience in the literature. Such terms as *self-efficacy* and *self-esteem* (Rutter, 1985), *positive future expectations* (Wyman, Cowen, Work, & Kerley, 1993), *good coping* (Murphy & Moriarty, 1976), *primary* and *secondary control coping* (Thurber & Weisz, 1997), *personal control* (Walsh, 1998), *problem solving* (Werner, 1995), *initiative* (Wolin & Wolin, 1993), *optimistic thinking* (Seligman, 1995), and *internal motivation* (Masten, 2001) have been identified as protective factors of resilience in studies across heterogeneous populations and environments. These terms mean that resilient individuals have a realistic, positive sense of self. They regard themselves as survivors (Wolin & Wolin, 1993). They feel that they can have an impact on their environment or situation, rather than just be passive observers. They are hopeful about the future. They are confident in their ability to surmount obstacles (Werner, 1993), make use of resources and opportunities around them, and view hardships as "learning experiences" (Werner & Smith, 2001). Resilient

individuals take positive action in their lives, such as seeking mentors, pursuing educational opportunities, participating in extracurricular activities, and choosing supportive mates (Werner, 1993; Werner & Smith, 2001). Those who possess a high degree of "perceived self-efficacy" are more likely to interpret successes as an indication of their capabilities (Bandura, Pastorelli, Barbaranelli, & Caprara, 1999). Seligman (2002) pointed out that when people think adverse events are permanent and pervasive for long periods of time, they assume feelings of helplessness and hopelessness. In contrast, he noted, when they think that negative things are temporary, this attitude encourages resilience.

Teaching children to help others is an effective way to promote responsibility, empathy, and self-esteem (Brooks, 1994; Werner, 1993). Giving of oneself in an effort to ease the plight of others, such as contributing time and effort at a soup kitchen, nursing home, hospital, and so forth, fosters resilience. Similarly, "required helpfulness" (Rachman, 1979) refers to the process that occurs when an individual is striving to overcome adversity and during the course of this pursuit is required to perform actions to help others in their personal times of need.

Self-Regulation

One of the most fundamental protective factors is success in developing self-regulation or self-control. Masten and Coatsworth (1998) define self-regulation as gaining control over attention, emotions, and behavior. If a child is able to modulate her emotions and behavior and can self-soothe or calm herself, she will most likely elicit positive attention from others (including parents) and will have healthy social relationships. She will more likely be independent and will be more able to put things in perspective. Easygoing temperament and good self-regulation have been identified as protective factors in resilience (Buckner, Mezzacappa, & Beardslee, 2003; Eisenberg et al., 1997, 2003; Werner, 1993). Additionally, impulse control and delay of gratification are part of self-control. The ability to self-regulate also seems to be at the core of good interpersonal relationships and peer relationships (Rubin, Coplan, Fox, & Calkins, 1995), rule compliance (Feldman & Klein, 2003), reduced risk of depression and anxiety, and a host of other areas fundamental to successful adaptation and functioning.

Common sense would dictate that positive emotionality should result in positive outcomes. Although this is true, recent research indicates that perhaps it is not positive or negative emotion per se that is the critical variable in adaptation, but the ability to *regulate* the emotion. In a longitudinal study of 5-year-olds, Rydell, Berlin, and Bohlin (2003) found that low regulation of positive emotions and exuberance was correlated with externalizing problem behaviors and low levels of prosocial behavior, whereas high regulation of positive emotions and exuberance was associated with high levels of prosocial behavior.

Proactive Parenting

Children with at least one warm, loving parent or surrogate caregiver (grandparent, foster parent) who provides firm limits and boundaries (Masten & Coatsworth, 1998) are more likely to be resilient. They tend to be more compliant with their parents (Feldman & Klein, 2003) and have better peer relationships (Contreras, Kerns, Weimer, Gentzler, & Tomich, 2000). A significant longitudinal study that began in 1959 has identified the *authoritative*

parenting style as associated with "optimal competence" in children and adolescents (Baumrind, 1989). Authoritative parents are characterized as "responsive" and "demanding" (Baumrind, 1991). Responsive parents are warm, loving, and supportive and provide a cognitively stimulating environment. They are also demanding in that they apply rational, firm, and consistent, but not overbearing, control on their children and place high behavioral expectations on them (Baumrind, 1991). Eisenberg et al. (2003) found that maternal expression of positive emotion is related to children's social competence and adjustment. Correspondingly, Rubin, Burgess, Dwyer, and Hastings (2003) found that dysregulated toddlers who experienced high levels of maternal negativity had a greater likelihood of externalizing problem behaviors 2 years later than toddlers whose mothers showed low to average levels of negativity.

Connections and Attachments

The desire to belong and to form attachments with family and friends is considered a fundamental human need (Baumeister & Leary, 1995). Multiple positive health and adjustment effects have been associated with a sense of belonging and attachments. It is also through supportive relationships that self-esteem and self-efficacy are promoted (Werner, 1993). Having social competence and having positive connections with peers, family, and prosocial adults are significantly related to children's ability to adapt to life stressors (Masten & Coatsworth, 1998). Resilient children also elicit positive attention from others (Werner, 1993).

For children, the development of friendships and the ability to get along with peers individually and in groups is paramount. Friendships provide support systems that can foster emotional, social, and educational adjustment (Rubin, 2002). Being part of at least one best friendship may also improve children's adjustment (Hartup & Stevens, 1997). Positive peer relationships have been shown to protect children during times of family crisis. Acceptance by a group lowers the risk of externalizing behavior problems (Criss, Pettit, Bates, Dodge, & Lapp, 2002). A child who has friends and is well liked is less likely to be bullied or otherwise victimized (Pellegrini, Bartini, & Brooks, 1999; Rubin, Bukowski, & Parker, 1998).

Although possessing a strong social support network renders children less vulnerable to stress, depression, and externalizing problems, the availability of social supports cannot be taken for granted. "Social support is not a self-forming entity waiting around to buffer harried people against stressors" (Bandura et al., 1999, p. 259). An active process is involved, and children, like adults, need to create and maintain supportive relationships. Connections affect how one treats and responds to others and how they, in turn, respond, thus forming a reciprocal relationship. It is easier for people to respond with more positive feedback and affection to an easygoing child who is sensitive to others and shows good self-control than to a child who is impulsive, who overreacts to events, and whose emotions are not well regulated. Children who share, who are compliant with social rules, and who are positive with peers are more likely to sustain their relationships.

School Achievement and Involvement, IQ, and Special Talents

Schools give young people a chance to excel academically and socially. Educational aspirations (Tiet et al., 1998) and active

engagement in academics (Morrison, Robertson, Laurie, & Kelly, 2002) have been associated with resilience in challenged youth. Although the reasons for this are not yet clear, a number of factors are likely to contribute. Encouragement from teachers fosters resilience through connections, as noted above. Further, involvement in extracurricular activities such as art, music, drama, special interest clubs, and sporting activities gives youth opportunities to participate in prosocial groups and achieve recognition for their efforts. A positive orientation toward school and school activities has been shown to protect against antisocial behavior (Jessor, Van Den Bos, Vanderryn, Costa, & Turbin, 1995).

Cognitive ability has been found to be associated with resilience in children (Fergusson & Lynskey, 1996). It also appears to exert a strong influence on other factors that contribute to resilience. For example, strong cognitive skills may allow youth to excel in school, as well as to make the most of educational opportunities and cultural experiences. Additionally, a commitment to school helps to counter the risk of violent behaviors (Department of Health and Human Services, 2001).

Fostering competence in children is central to resilient outcome. Brooks and Goldstein (2001) believe each child possesses at least one small "island of competence," or area that has the potential to be a source of pride or achievement. Fostering resilience in youth requires that parents highlight children's areas of competence to help them experience a sense of accomplishment. They suggest involving children in daily activities that allow them to feel they are contributing to the world. Examples include assisting other children, acting as a school patrol, or helping an older neighbor.

Community

Community factors, including the availability of supportive relationships outside of the family (Masten, 2001; Werner, 1995), are also well documented as having a protective influence on children. Resilient youth form relationships with positive role models and elders outside of their own family (Wolin & Wolin, 1993). Youths often join clubs, teams, and other groups and frequently find mentors such as coaches, teachers, scout leaders, and other prosocial adults in their communities. Effective schools identify the needs of their students and address those needs with services, as well as by consideration of class size and curricula.

Important elements of an effective community are environments and social structures that promote resilience. Early prevention and intervention programs, safety in neighborhoods, support services, recreational facilities and programs, accessibility to adequate health services, and economic opportunities for families have all been identified as protective factors (Thomlison, 1997). Religious and spiritual organizations may also serve as buffers, providing services and social support within the community.

Implications for Individual and Family Clinical Interventions

The following intervention strategies emphasize strengthening assets and protective factors.

1. Teach children and families problem-solving skills to identify controllable and uncontrollable circumstances and adversities. Cognitive problem-solving skills training has been well documented in the literature (Kazdin & Weisz, 1998). Therapists and parents can model problem solving by talking out a particular

situation and identifying steps to be taken. Children should be asked questions to encourage them to generate alternatives and options (Bloomquist, 1996).

2. Encourage children to express their feelings, both positive and negative. Emotional upset during and after traumatic events is normal, and children need the opportunity to talk about their concerns (Grados & Alvord, 2003).

3. Help children and families to identify strengths and positive family experiences. Families should be encouraged to have "special time" to promote relaxing and constructive interactions (Barkley & Benton, 1998). Humor can be a healing and coping tool in times of stress (Brooks & Goldstein, 2001; Wolin & Wolin, 1993), making activities or interactions that might encourage fun and laughter important.

4. Guide parents and teachers in fostering self-esteem in children through meaningful responsibilities whereby children may gain a sense of accomplishment and mastery. Provide children with opportunities for developing and nurturing their talents (Brooks & Goldstein, 2001). Encourage them to try to see whether they can effect some change. Teach them that mistakes are okay and that they can be a valuable learning tool.

5. Teach optimistic thinking and perspective taking. Help children to realistically attribute successes to themselves and not simply to environmental circumstances. Cognitive restructuring can be used to help children change the way they judge their accomplishments (Bandura, 1997). Seligman's Penn Program (Seligman, 1995) develops optimistic thinking in children by teaching them to become aware of their thoughts, assess how realistic they are, generate more accurate explanations, and decatastrophize thoughts about negative events. Children who are able to think of negative events as temporary rather than permanent tend to be more resilient (Seligman, 2002). One of our child clients said that she learned in therapy that "bad things and thoughts don't last forever and it may take awhile to bounce back."

6. Teach cognitive strategies such as thought stopping and *changing channels*. In this latter technique, children make TV sets from folders and paper and assign station numbers to various feelings. Children are taught that if their thoughts and emotions are on the "angry channel," they can switch to the "calm channel."

7. Teach relaxation and self-control techniques. Techniques such as deep breathing, progressive muscle relaxation, visualization, and guided imagery add to a child's skills to self-regulate. One technique for younger children is the "turtle technique" (Robins, Schneider, & Dolnick, 1977), a modified progressive relaxation and problem-solving strategy in which a child imitates the action of a distressed turtle; the child mimics the turtle by retreating into its "shell" and then contemplates possible solutions to the problem. Another is called "rag doll" (Moser, 1988), a relaxation exercise in which the child tightens his entire body and then slowly bends over until his arms are loose and swing like a rag doll's. Engaging in sports activities and physical exercise can also promote relaxation. Teaching a child to distract himself with an activity can help take his mind off his anxiety. For example, a common way in which children may cope with homesickness is to do something fun to take their minds off it (Thurber & Weisz, 1997).

8. Teach parents that the critical factors in fostering resilience in children are warmth, limit setting, and consistency. Children benefit from routines and a sense of order in their lives. Parents also need to help their children believe in themselves by setting real-

istically high expectations for them. In this way, parents inspire their children to recognize that they can make things happen by being proactive. They need to encourage the development of self-sufficiency and independence by giving children age-appropriate choices and responsibilities. Parenting books such as *Your Defiant Child* (Barkley & Benton, 1998), *Raising Resilient Children* (Brooks & Goldstein, 2001), and *How to Discipline Without Feeling Guilty* (Silberman & Wheelan, 1980) can be helpful.

Implications for Group Interventions

In this section, we consider group intervention strategies that we have found to be effective. In this era of managed care, with emphasis on providing cost-effective psychological services, group therapies have enjoyed widespread popularity among clinicians. Social skills groups offer effective treatment interventions (Pfiffner & McBurnett, 1997; Tynan, 1999). They can be offered at a relatively low cost and are the treatment of choice for peer-related issues. In the following, we describe our group model, which applies what is recognized in the field about promoting resilience in young people and capitalizes on the protective influences that may serve to buffer them from stress.

The Alvord–Baker Social Skills Group Model

The Alvord–Baker model of social skills groups is a resilience-based curriculum that focuses on a proactive orientation and cognitive–behavioral strategies. Children exist as part of families and communities. Therefore we present a systems model that coordinates treatment with school and community resources as appropriate.

Groups are presented to the community as “social skills groups.” Thus, parents are less affected by the stigma that might be related to seeking mental health services. Children feel a sense of belonging and acceptance as being part of a group. The model is designed for 12–14 sessions per semester paralleling the academic year, with two consecutive semesters of attendance recommended for maximum benefit. Each group may include up to six children and is facilitated by a single clinician. It assumes a fee-for-service model of practice.

Groups are composed of children of the same gender but with mixed diagnoses, for example, ADHD and anxiety disorders (particularly social anxiety symptoms). A limited number of children with mild Asperger’s disorder are included in the groups. Some children also have learning disabilities and fine-motor/gross-motor skills deficits. Children with below average intellectual capability or severe aggressive behavior are not appropriate for this group model. Research indicates that placing antisocial youth together results in interventions that are often ineffective and may even increase the likelihood of delinquency (Dishion, McCord, & Poulin, 1999).

Groups based on this model have been operating in our practice for the past 12 years. What is described below applies particularly to groups for children in second through fifth grades. Groups for kindergarten through first grade and middle school-age children use the same model. However, the activities are modified to be more developmentally appropriate.

The model consists of five structural components: (a) the interactive didactic component, during which the children are asked to

think, offer ideas, and actively learn new skills; (b) the free-play component, during which children must negotiate and interact; (c) the relaxation/self-regulation component, during which children practice stress-reduction and self-regulation strategies; (d) the generalization component, during which the children apply what they have learned outside of the group; and (e) the parental component, in which parents are informed of skills taught in each session and are encouraged to actively participate and guide their child through the homework assignment given each week.

Group rules are clearly defined in the first session and reinforced with a reward system throughout future sessions. Children are active participants in developing the rules. Rules generally include talking one at a time, staying in one’s personal space, playing cooperatively, and talking nicely. A systematic behavior reward system is implemented that includes charting points for each child. Children can earn points for following group rules, completing and discussing their homework, talking about their progress toward their individual goals, and taking part in the self-regulation technique of the day. Points can be traded in for a small prize every few sessions or accumulated to earn something more attractive, exposing children to the idea of delayed gratification. In each session, one child is selected to receive the leadership award (a small certificate) on the basis of leadership qualities or actions that the children have previously identified.

The Interactive Didactic Component

The interactive didactic component involves identifying the resilience factors and social skills that we want to teach. We introduce this process not by lecturing to children but by guiding them. We ask for their input, thus modeling collaboration and encouraging them to actively participate. By generating their own ideas, children receive positive feedback, remember their ideas better, and feel empowered. For example, the therapist may have determined from parent feedback that the children need to work on problem solving. The therapist would introduce the concept and then elicit from the youth what the elements of problem solving are and what they mean. The children are then asked to identify a problem and discuss what might have caused it, how another person might feel, and what each thought in this situation. The children discuss how they would individually feel in the same circumstances. They also explore possible solutions to the problem.

After the discussion, the children identify actual experiences they have had that fit the topic and role-play possible actions. In the case of problem solving, a child might offer that he wanted to join a soccer game during recess but did not. The children take turns playing a variety of roles, practicing both counterproductive responses and responses that would result in a positive impact on others. The role-playing is followed by a discussion in which the children identify what worked and what did not. Other activities used to model appropriate behaviors and responses may be puppet shows, interactive stories, and books (Alvord & O’Leary, 1985).

One important piece of the interactive didactic component is that each child (with his or her parent) must select an individual goal to work on throughout the course of the semester. This encourages children to take responsibility for an area of need as they identify strengths that will help them attain the goal. One child might decide to work on managing his anger; another might choose to work on initiating and maintaining a conversation with

a peer, and a third might decide to work on joining group activities. At each session, each child shares what happened during the prior week that relates to his individual progress. The others listen, often empathizing by sharing comparable situations they have encountered. One child had the problem of interrupting conversations, and so he set a goal to remember that only one person talks at a time. In a collaborative effort, the group came up with a "rule" that we have since expanded on, called the *one-minute rule*, which says to stop, look, and listen. Before taking action, saying something, or joining in a conversation or activity, the child must *stop* (for one minute), during which he is to *look* (at what others are doing), *listen* (to what others are talking about), and then decide to join, take action, or choose to say or do nothing. Coining a name for a rule or process helps children remember it.

Free Play and Behavioral Rehearsal

Once the didactic part of the session has ended, the children move to free play. Children who are resilient are good at compromising and are flexible in their thinking. This allows them to cope with disappointments better because they are able to see other options. The point of free play is to offer a real-life play situation in which children undergo a structured process of negotiation and compromise. Because one of our rules is that each child must play with at least one other child, the children learn to reach consensus on what they would like to play together. During this process, each states his choice of a game or toy. This process is continued until all children are paired or in a group. The next challenge is to sustain play while being a good sport.

One key to free play is that the children view it as a fun and natural activity, while the therapists use it to change behavior as it occurs. Through behavioral rehearsal, therapists intervene to stop the "incorrect" interaction and have the children replace it with a "correct," prosocial behavior and then practice until it is right. Too often these children have been told what not to do and do not know *what* to do. Children come to understand that mistakes are okay and that they can think of ways to learn from their mistakes and fix them.

Relaxation and Self-Control Techniques

One of the inner strengths that resilient individuals possess is the ability to self-regulate emotions and behavior. Many children who are at risk, such as those with ADHD, lack self-control and experience dysregulation (Barkley, 1997). In this group model, one or more self-regulation techniques such as progressive muscle relaxation and visualization are taught or practiced during each session. Children are introduced to many strategies so they can decide what works best for them. After several sessions, children take turns leading the exercises (i.e., the visualization). In this way, children acquire mastery of the techniques and come to see the value in an active approach.

Generalization

It is important to generalize change to the natural settings of home, school, and community to promote resilience. Goldstein and Martens (2000) have written a book devoted to methods for enhancing generalization of change. They attribute the failure of many strategies to generalize to the lack of a deliberate generalization program.

They claim that it is the repeated practice of *successful attempts* that increases generalizability.

One critical feature of our model is the incorporation of multiple strategies to increase the likelihood of generalizing the changes brought about by the groups through weekly practice. Strategies include weekly homework assignments (which we call "learning enhancements"), involvement of parents, and, when appropriate, collaboration with the child's school.

A learning enhancement (T. Verratti, personal communication, February 4, 1999) or homework is assigned weekly. Learning enhancements foster active coping by requiring practice of the skill discussed and rehearsed in the previous session. The practices are then documented on checklists or written assignments. We stress that, as with musical instruments, one must practice what one has learned between lessons to optimize gain. If children have difficulty with writing, assignments may be dictated to parents. In any case, parents must initial the assignment each week. This promotes discussion of the skills, children's ideas, and their performance.

During our intake, teachers complete the Behavior Assessment System for Children if parents have given consent. Also, collateral contact with teachers and other professionals in the child's life (e.g., individual therapists, school counselors, learning specialists) is undertaken when appropriate. We encourage parents to share our learning enhancements with school personnel so that skills can be reinforced in the school setting.

We encourage children to participate in teams and groups outside of the school day to develop their connections with the community (e.g., sports, martial arts, scouts). We ask that parents reinforce the demonstration of skills in these settings. Often sports coaches (at the elementary school level) like to know the issues and wish to work with parents to reinforce positive behaviors in the children.

Parents as Active Partners

Parents are involved in a variety of ways. Each child has a folder in which parents and therapists communicate. At every group session, parents receive a letter in their child's folder explaining what skill is being worked on and why it is important, some tips on how to foster the behavior or thought pattern, and the learning enhancement of the week. The folder is also another means for parents to provide information to the therapist. Once a month, parents (or the caretaker who brings the child, such as a grandparent or nanny) join the last 15 min of the session so that children can share what they have been working on. We practice self-esteem-promoting activities every session, for example, children complimenting one another and making positive statements about their strengths and accomplishments. These are shared with parents during the meeting. Although parent groups have been offered to promote generalizability (Pfiffner & McBurnett, 1997; Tynan, 1999), we have found that it is impractical to require them to participate in separate weekly parenting groups (owing to expense, time, coordination of schedules, and so forth). However, we do offer a variety of groups, some time limited and others that have lasted over several years (moms' groups, dads' groups, parents' groups on behavior management, and so on), and we encourage participation in them. We also make available individual parent meetings with the therapist and require that parents attend at least one per semester.

Conclusion

Studies over the past four decades have identified characteristics and protective factors of individuals, families, and communities related to resilience. Resilience should be seen as an acquired, gradually internalized, generalized set of attributes that enable a person to adapt to life's difficult circumstances. It involves action. It means taking charge of one's life. Youth who are resilient are proactive when faced with challenges. They adapt to difficult circumstances by using internal as well as external resources. They are realistic. Resilient children come to understand that although they cannot control everything, they do have some power to influence what happens next. The Alvord-Baker social skills group model incorporates the protective factors found in the literature and provides a practical, proactive, cognitive-behavioral approach to foster resilience in children. The practical implementation of these procedures by clinicians, along with the active participation of the children and their parents, results in an integrated approach that helps develop and enhance resilience.

The Alvord-Baker social skills group model has been an integral part of our practice for the past 12 years. During the past 5 years, we have been collecting information from parents and teachers, and in the past 2 years, empirical data, in an attempt to evaluate the effectiveness of our model.

We feel the task ahead is twofold. First, clinicians should apply what is known about factors that promote resilience to a variety of treatment modalities and child populations. Second, although resilience-based interventions clearly benefit children, empirically based effectiveness studies are needed to measure progress in the field.

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